## ADULT INITIAL HISTORY AND PHYSICAL

Today's Date://	/ Age: Family Doctor:		□LEP: Interpreter							
Please complete the follow	wing inform	ation:								
What is the main reason for your visit today?										
Are you having any problems or symptoms today that you would like to discuss? ☐ yes ☐ no If you answered yes, please briefly explain:										
Are you allergic to any medicines or foods?  yes  no  no  If you answered yes, please list what medicines or foods you are allergic to and your reaction to each:										
Current medications ( <i>Prescription / Over the counter</i> ):  None  Multivitamins										
Have you had any hospitalizations, major injuries, or surgeries? ☐ yes ☐ no										
If you answered yes, please briefly explain:										
Living Conditions: ☐ Alone ☐ With family: # of children in home ☐ With Roommate ☐ In group or foster home										
Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed										
Education:  Not a student.				Employment: 🗖 N						
Highest education level completed:				Currently emplo	/ed: Where?					
□ Current Student: School Grade										
Please check if you have or have had	d any of the follow	ving: 🔲 NO CU	IRRENT COMP	PLAINTS						
CONSTITUTIONAL	HEAD, FACE, N	ECK	CARDIOVAS		RESPIRATORY					
☐ Fatigue	Headaches		Angina or		□Asthma or Wheezing					
□ Difficulty sleeping	Reduced facial		Chest pain		Difficulty breathing					
☐ Fever/chills	□ Recent hair lo			egular heart beat	Cough with mucous production					
■ Night sweats	Scalp tendern		Swelling of		Chronic or frequent coughs					
☐ Recent weight change	☐ Swollen gland	Is in the neck	<ul><li>□ Poor circul</li><li>□ Blood clots</li></ul>		<ul><li>□ Dry cough</li><li>□ Pain on breathing</li></ul>					
EYES	CHEST/BREAST		☐ High blood	pressure	☐ Spitting/coughing blood					
■Blurred or double vision	Breast discha	rge	-							
□Dryness / Redness	Breast lump		GENITOURI	NARY	MUSULOSKELETAL					
Wear glasses or contacts	Breast pain			painful urination	□ Back pain					
☐ Cataracts	Breast implan	ts	☐ Blood or po		□ Cold extremities					
☐ Glaucoma				ce or dribbling	Numbness or tingling					
	GASTROINTESTINAL		Vaginal dis		☐ Paralysis					
EARS/NOSE/MOUTH/THROAT	☐ Heartburn or indigestion		Irregular p		☐ Joint pain					
□Earaches or drainage	☐ Loss of appetite		☐ Painful per		☐ Joint stiffness or swelling					
☐Ringing in the ears	☐ Abdominal pain		☐ Prostate p		☐ Weakness of muscles or joints					
☐ Hearing loss	☐ Changes in bowel habits		☐ Testicular		☐ Walk with assistive device					
☐Sinus infections/problems		Painful bowel movements		iculty	☐ Difficulty climbing stairs					
□Nosebleeds	□ Constipation		☐ Genital ras	sn or uicers	NEUDOLOGICAL / REVOLUATRIO					
□Frequent sore throat	☐ Frequent dia		OLCINI		NEUROLOGICAL / PSYCHIATRIC					
□Dryness of the mouth	☐ Hemorrhoids/blood in stool		SKIN  ☐ Rash or itc	la fina es	☐Convulsions or seizures					
□Bad breath/bad taste		☐ Nausea or vomiting			☐Tremors					
☐ Mouth sores/ulcers	☐ Abnormal liver tests/ liver disease		<ul><li>□ Change in</li><li>□ Change in</li></ul>		☐ Memory loss or confusion☐ Light headed/ Dizziness					
□Voice changes	ENDOCRINE			SKILL COLOI	Loss of consciousness					
☐Bleeding gums	☐ Diabetes		<ul><li>☐ Psoriasis</li><li>☐ Skin nodul</li></ul>	ae ar humne	□ Stroke					
☐ Difficulty swallowing☐ Dentures☐	☐ Thyroid disea	22		☐ Depression						
□ Dentures □ Thyroid disease □ Easy bruising □ Depression □ Excessive thirst □ Sores that won't heal										
Change in talerance to bot/cold weather										

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Please ✓ those that apply to you or your blood relatives. You Father Mother Brother Sister Grandparent Child (Patient) HIV/AIDS Alcohol / Drug Addiction Alzheimer's Arthritis Asthma Birth Defects Bleeding Disorder / Free Bleeder Cancer COPD / Emphysema / Chronic Bronchitis Diabetes Epilepsy / Convulsions / Seizures Heart Attack / Stroke High Blood Pressure High Cholesterol Kidney Disease Liver Disease / Hepatitis Mental Illness / Depression Osteoporosis Sickle Cell Thyroid Disorder Tuberculosis/TB Other: Nutrition: check foods you eat every day Do you have concerns about your Exercise ■Milk / Dairy □Meats □Vegetables weight? □Yes □No ■ None □ Seldom Occasional □ Frequent □ Fruits □ Breads or Grains Street Drugs Mental Health: (in past 90 days) Tobacco Use / Smoke Exposure Alcohol ■ Never used ■ Exposed to smoke ■ No Problem □None □None □Seldom: type \_\_\_\_\_ □Occasional: type \_\_\_\_\_ ☐ Past user: type \_\_\_\_\_ ☐Seldom: type \_\_\_ ☐ Mild/Moderate Depression ☐Use now: type \_\_\_\_\_ □Occasional: type \_\_\_\_\_ ☐ Severe Depression (# per day \_\_\_\_) ☐Frequent: type \_\_\_\_\_ ☐Frequent: type \_\_\_\_\_ ■ Anxiety ☐ Thoughts of harming self / others Dental Health Water Source: Travel: ☐No travel outside USA ☐Brush daily ☐Floss daily □ Well □ Cistern ☐Traveled outside USA: ☐ City □Visit dentist every 6 months ■ Bottled Country/Year Sexually Active with: ☐ not sexually active Abuse / Neglect / Violence: Females only: Do you examine your breasts every month? Yes No □ No fear of harm □ Pressure to have sex □Males □Females □ Both □ Daily needs not met □ Forced sexual contact Number of partners: in past month \_\_\_\_\_ in past 2 months \_\_\_\_ | First day of last menstrual period:\_\_\_/\_\_/ ☐ Fear of verbal/physical abuse in past 12 months \_\_\_ ☐Sex for money or drugs **Reproductive Life Plan:** Do you have any children? ☐ yes ☐ no Do you want more children? ☐ yes ☐ no

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**Healthcare Provider Signature:** 

Date:

If yes, how many more children do you want to have and when?

Patient Signature:

What type of birth control are you using to prevent pregnancy?

TO BE COMPLETED BY HEALTHCARE PROVIDER							
FEMALES ONLY	MALES ONLY						
Age of menarche:	# living children:						
# Days between periods: # Days of bleeding: Problems with menses:  very yes  no	Fertility problems: ☐ yes ☐ no Describe:						
Describe:	Hx of testicular biopsy: ☐ yes ☐ no						
Age at first pregnancy:	Date / Year:						
G Para SAB ETP # living children:	Result:  PSA testing:						
Hx of NTD:  yes  no	Most recent date / year: Result:						
Age at last pregnancy:							
Date of last delivery:	Hx of abnl PSA: ☐ yes ☐ no						
Fertility problems: ☐ yes ☐ no	Date / Year:						
Describe:	Result:						
Currently using contraception: ☐ yes ☐ no Type:	Digital rectal exams: ☐ yes ☐ no Most recent date / year: Result:						
Interruption in B/C method?							
Menopausal symptoms:	Hx of abnI digital rectal exam: □ yes □ no						
Describe:	Date / Year:						
HRT: ☐ yes ☐ no	Result:						
Type:	Sigmoidoscopy: ☐ yes ☐ no						
Age at final menses:	Date / Year:						
Rubella status: unknown	Result:						
DES Exposure: ☐ yes ☐ no ☐ unknown  Routine Pap Tests: ☐ yes ☐ no	FOBT: □ yes □ no Year: Result: □ pos □ neg						
Most recent date / Year: Result:	Colonoscopy:						
Hx of abnl pap / HPV: □ yes □ no	Result:						
Date / Year: Result:	SEXUAL HISTORY						
Hx of colposcopy/biopsy: ☐ yes ☐ no	Sexual partners: ☐ men ☐ women ☐ both						
Date / Year: Result:	# Sexual partners: lifetime last year						
Mother,sister,daughter with breast cancer < age 50? ☐ yes ☐ no	last 60 days last 30 days						
Currently breastfeeding: ☐ yes ☐ no Ever breastfed: ☐ yes ☐ no	Sex with anonymous partners: ☐ yes ☐ no  First sexual contact <18 yrs of age: ☐ yes ☐ no						
Routine Mammograms:  yes  no	First sexual contact <18 yrs of age: ☐ yes ☐ no  Bleeding, spotting, pain with intercourse: ☐ yes ☐ no						
Most recent date / Year: Result:	Describe:						
Hx of abnl mammogram / CBE: ☐ yes ☐ no	Condoms used routinely: ☐ yes ☐ no						
Date / Year: Result:	Hx of STDs: ☐ yes ☐ no						
Hx of breast biopsy: ☐ yes ☐ no	Hx of ≥ 2 STDs:						
Date / Year: Result:  FOBT: ☐ yes ☐ no Year: Result: ☐ pos ☐ neg	Disease(s):  HIV tested: □ yes □ no Most recent date:						
Colonoscopy: Q yes Q no Year: Result:	Result: pos pog						
Colonocopy. Type The Tour. Result.	Unprotected sex since last test: ☐ yes ☐ no						
Immunization Status: ☐ Up to date by patient report ☐ Records Requested	Lead Assessment: Verbal Risk Assessment: ☐ neg ☐ pos ☐ N/A						
☐ See Vaccine Administration Record ☐ Vaccines given today	Tested Today: ☐ yes ☐ no Referred for testing: ☐ yes ☐ no						
Preventive Health Education: topics discussed today	Educational Handouts:						
☐ Child development ☐ Safety ☐ Preconception	·						
☐ Immunizations ☐ Mental Health ☐ Prenatal / Gene							
□ Dental □ DV/SA □ SBE /Mammog □ Hearing/Vision □ ATOD / Cessation / SHS	Ontions Counsoling   Millor Family Planning						
☐ Lead exposure (ACH-25a) ☐ Diabetes ☐ Osteoporosis	Reproductive Life Plan   Counseling. Abstinence						
☐ Diet / Nutrition ☐ CVD ☐ Cancer	Sexual coercion  Benefits of parental						
☐ Physical activity ☐ Arthritis ☐ STE / PSA	involvement in choices						
Patient verbalizes understanding of education given							
Healthcare Provider Signature: Date:							

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SUBJECTIVE	/ PRESENTING	PROBLEM	И:								
OD IECTIVE.	Compared Musiki	Custom F	Tura madia na								
SYSTEM	General Multi-	System E NL					SYSTEM		NL	ABNORMAL	
STSTEIN	General appearan		ADNORIVIAL	-				Neck,Axilla,Groin AC	INL	ADNORWAL	
Constitutional	Nutritional status	CE		-			Lymphatic	Spine Spine			
				-	1		Musculoskeletal	ROM			
HEENT	Vital signs	Cools .		- /		1	iviusculoskeletai				
	Head: Fontanels, S	scaip		-	/ /		01: /00 T	Symmetry			
	Eyes: PERRL			-	$\wedge$			Inspection(rashes)			
	Conjunctivae, lids							Palpation (nodules)			
	Ear: Canals, Drur	ns		-     //	\\		Neurological	Reflexes			
	Hearing			1 / ([	(( . )) (		. tour orogroun	Sensation			
	Nose: Mucosa/ Se			- Gurl	1 //2		Psychiatric	Orientation			
	Mouth: Lips, Palate	е			/wv		,	Mood / Affect			
	Teeth, Gums			\			EXPLANA	ATION OF ABNOR	RMAL	FINDINGS:	
	Throat: Tonsils										
Neck	Overall appearance	е		1 /		, )					
IVOOR	Thyroid			\	\    /   \ }_	. (					
Respiratory	Respiratory effort										
respiratory	Lungs			] ,	/	1					
	Heart			4	un (mi)						
Cardiovascular	Femoral/Pedal pul	ses			, c						
	Extremities					/\					
	Thorax			7	- (	. \					
Chest	Nipples			1//		/					
	Breasts			7 ( /							
	Abdomen			1 4			Tannar Cta	ma. Dhumiaal [	7 -4.	m:	
Gastrointestinal	Liver / Spleen				~		Tanner Stage: ☐ typical ☐ atypical			picai	
	Anus / Perineum		1	X-Ray: Type:			Re	Result:			
	Male: Scrotum						Date taken:		No Cha	ange	
	Testes	Testes Penis			Date taken:				□Neg/Non-remarkable		
	Penis										
	Prostate			( >	( ~ )		Date compared with:		□Improved		
									Worse	ning	
Genitourinary	Female:Genitalia				\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \		TB Classification: ☐ TB suspect				
	Vagina				(		□0 No TB exposure, not infected				
	Cervix			1			☐I TB exposure, no evidence of infection☐II TB infection, without disease				
	Uterus			1		,					
	Adnexa	xa				□III TB, clinically active					
						□IV TB, not clinically active Site of infection: □PulmonaryCavityNon Cavity □ Other:					
ASSESSMEN'							Site of fillection.	TruillionaryCavity	INU	ir Cavity 🖵 Other.	
AGGEGGWIEN	1.										
PLAN:											
PLAN:											
Tasting taday	D NI/A	Madiadia	/0		Recommendations r	d. 4	aliant faraahad	uling of Defermels		- D N/A	
Testing today:			ns/Supplies:				•	•			
☐ GC/Chlamydia urine ☐ N/A ☐ MV / Folic Acid				follow-up testing and procedures, based on				PCP, Medical Home			
	dia swab				assessment: □ N/A		DI EDC	HANDS		□ WIC	
□ UA			of bottles given		☐ Vision	☐ Hear		- 1 00101110		☐ FP	
☐ Hep C ☐ TST ☐ Birth Control Method			_ □ Dental □ Lipid Screen □ Hgb			☐ Specialis					
□ VDRL □ HIV □ given □ Rx			□ Pap Smear □ Sickle Cell □ Lead			☐ Radiolog					
□ Pap □ Lead □ Foam Issued (#)			☐ Mammogram ☐ Ultrasound ☐			☐ MNT wit					
☐ Hgb ☐ Cholesterol ☐ Condoms Issued (#)			UCG/HCG				☐ Medicaid				
☐ Blood Glucose ☐ Foam/Condoms offered;			☐ Bone Density ☐ Liver Panel				☐ Social Services				
☐ Urine PT / UCG: ☐+ ☐- pt. declined		ned		☐Blood Glucose		rectal Scr.		☐ 1-800-QUIT-NOW			
Planned?  Yes No				☐Ovarian Cancer Scr	Other	r:		☐ Freedom from Smoking			
□Wet Mount	,o <b>—</b> 140							☐ Other:			
Other:											
	Provider Signatu	ro:			Date:		Recommended	I DTC.			
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